

# Emergency Medicine and the Underage Athlete

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**Abstract:** *Most high school and some collegiate athletes are legal minors. In civil matters, the law treats minors (usually individuals under the age of 18 years) uniquely. Limitations exist on a minor's ability to enter into contracts, make determinations regarding medical care, and bear responsibility for personal actions. Medical professionals are often unclear on matters relating to the provision of medical care to minors. The purpose of this discourse is to present selected legal issues in the context of two fictional case studies. Case 1 presents issues regarding the definition of emergency medical conditions and the related emergency medical doctrine. Case 2 provides an example of an acute medical concern which fails to fall under emergency medical classification but rather provides a context for discussing the mature minor doctrine. Both cases are analyzed in light of these doctrines in addition to other pertinent legal considerations.*

Many athletic trainers have the opportunity to work with athletes who are legal minors. Special legal concerns present themselves during interactions with minors including consent for emergency medical care, nonemergency care of the mature minor, and the salience of consent forms often used by schools and athletic organizations.

When treating minors, no medical procedures should be performed without consent of a parent or guardian.<sup>1</sup> However, parents cannot always be contacted at the time of an emergency. For this reason, legislatures and courts have articulated what can be referred to as the emergency medicine doctrine for minors. The Juvenile Justice Standards Project, Rights of Minors, Part IV: Medical Care (JJSP) outlines conditions under which a minor may receive medical care without parental consent. The JJSP states that medical treatment may be administered when, "Emergency situations exist when delaying treatment to first secure parental consent would endanger the life or health of a minor." This doctrine is present in most state statutes to deal with consent for emergency medical care.<sup>1,10</sup>

The JJSP was initiated by the American Bar Association in the 1970s in an attempt to meet four basic needs: 1) achieve uniformity in the law relating to minors, regardless of jurisdiction; 2) develop linkages within the justice system to promote coordinated treatment of minors; 3) re-examine concepts underlying current laws and evaluate their strengths and weaknesses; and 4) codify relevant case material to serve, not as law, but potentially as a model for state acts and statutes.<sup>10</sup> This 23-volume series of analysis of current legal thought provides a comprehensive basis for the development of policies for dealing with minors' affairs in the legal system. The standards have been developed with the underlying premise that juveniles should have the right to decide on actions which affect their lives, unless they are found to be incapable.<sup>16</sup>

Mature minor doctrine defines the degree to which a minor, close to the age of majority, may determine the course of his or her medical care. The ability of a minor to enter into contracts varies from state to state. Decisions regarding nonemergency medical care are increasingly being placed in the hands of mature, capable minors.<sup>16</sup>

The following fictional cases illustrate the practical application of many legal concepts in athletic training scenarios.

## Case 1

Winston was a 16-year-old junior varsity football player. He attended a coed boarding school on the West Coast. His parents worked for the government and were living in Great Britain. In August, Winston entered school to begin preseason football practice. Prior to participation, he underwent a physical examination administered by the school physician and the athletic trainer, and was cleared for participation. His parents signed a consent form authorizing the school to act en loco parentis (in the place of parents and/or legal guardians) in all matters pertaining to his care and signed an additional release of liability form for participation in interscholastic athletics.

During the second week of two-a-day practices, Winston began losing weight and complained of recurring headaches. The athletic trainer encouraged him to increase his fluid intake to minimize the risk of dehydration and concomitant heat-related illness.

On a Thursday, during full-contact practice, Winston tackled an offensive player and fell to the ground, motionless. A student athletic trainer (a high school sophomore) covering the practice ran onto the field and observed that Winston was disoriented and had no coordinated use of his extremities. His pulse was rapid and strong. The student athletic trainer informed a coach who summoned the head athletic trainer, indicating that there was a medical emergency. Two minutes elapsed before the head athletic trainer arrived. At this point,

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Winston was unresponsive and his pulse and respirations were weak. The athletic trainer determined that Winston was suffering from heat stroke compounded by a possible neurologic insult.

Due to the remote location of the school, the school physician requested the dispatch of an Emergency Medical Service to transport Winston to the hospital. During the 45 minutes prior to the arrival of the EMS transport, the athletic director attempted to make contact with Winston's parents with no success. The athletic trainer provided care for heat stroke and episodes of cardiac arrest while waiting for the EMS to arrive.

At the hospital, Winston was diagnosed as having severe heat stroke. He was admitted for 2 days, during which time he was rehydrated. His parents were notified of the emergency 36 hours after the episode.

## Case 2

Samantha was a 17-year-old swimmer. While diving into a pool during summer vacation, Samantha dislocated her shoulder. She was taken to the emergency room, where the anterior glenohumeral dislocation was reduced.

While training for the backstroke, her shoulder repeatedly subluxated, at which times she was able to "pop" it back into place. As the swimming season arrived, she had too much pain to effectively train or compete. Conservative nonoperative treatment was ineffective in adequately stabilizing the joint. The athletic trainer referred her to a consulting orthopedist who recommended a surgical stabilization of the anterior joint capsule. Because she was planning on swimming in college, she requested that the operation be scheduled.

## Discussion

Emergency medical care requires special medical and legal consideration. Due to the nature of many emergency conditions, the provision of consent—ideally informed consent—is problematic in light of impaired mental status. In most jurisdictions,

patients are assumed to consent to emergency medical care unless previous orders regarding the refusal of medical care have been enacted (Do Not Resuscitate (DNR)-orders, and the like).<sup>1</sup> Prior to treating conscious, competent, injured adults, informed consent must be obtained.

Statutes authorizing emergency medical care for minors are widespread. Furthermore, those individuals who provide emergency medical care to minors enjoy certain protections from civil liability. A review of all immunity statutes would be cumbersome, but selected statutes demonstrate the wide range of specific protections provided by the law for individuals providing emergency medical care to minors. Any individual may provide emergency transportation and medical care to a child if no ambulance is available in Arizona.<sup>3</sup> In Arkansas, teachers, school health providers, and other school personnel are immune from civil liability for providing emergency medical care to minors.<sup>2</sup> The California Education Code provides immunity for individuals providing emergency medical care to athletes<sup>6</sup> and states that no community college, agent thereof, or physician shall be liable for illness or injury regardless of parental consent.<sup>7</sup> California, Virginia, and several other states provide physicians immunity from civil liability when providing emergency medical care to athletes (minor or adult) without compensation.<sup>5,14</sup>

State statutes authorizing emergency medical care for minors do not discourage attempts to obtain parental consent.<sup>1</sup> On the contrary, most mandate parental notification as soon as possible. It is essential to realize that parental consent is not necessary when life and limb are compromised by a delay while attempting to obtain parental consent. Barring gross negligence and/or willful and wanton misconduct, all medical personnel in Case 1 were free to provide necessary medical care without threat of civil liability. In Case 2, because the condition, though acute, was not an emergency, parental consent was necessary.

No state requires a signed medical release to authorize emergency medical care for minors. In Case 1, Winston would have received emergency medical care from the athletic trainer, the school physician, and the hospital emergency personnel regardless of the parental signatures on a consent form. Case 2 presents an entirely different medical situation, for no true emergency existed. The courts have been unified in the stipulation that for the emergency medical doctrine to be relevant, a true emergency must exist.

*Duda v. Gaines*<sup>9</sup> was an action brought by parents of a high school football player against defendants from the boy's high school. During football practice, the athlete had a shoulder dislocation which was reduced. Subsequently, he had recurring shoulder pain and stability deficits. The boy's parents alleged that the school personnel should have sought and provided medical care for the shoulder injury. The case was dismissed due to lack of evidence. The court did state that this condition was not an emergent one and therefore, it was incumbent on the parents to solicit medical care. In *Duda v. Gaines*,<sup>9</sup> the court clearly mandates that medical care without parental consent is only authorized in cases which represent true emergencies.

Case 2 provides a scenario in which the party responsible for providing consent may not necessarily be a parent. Samantha was 17 years old. Many states have embraced the mature minor doctrine. The mature minor doctrine empowers minors who have sufficient mental capacity to understand and comprehend the nature of a medical procedure, the risks involved and the probability of attaining the desired results to provide consent for themselves.<sup>1,17</sup> The JJSP suggests that a minor who consents for treatment, under the mature minor doctrine, should be accountable for the costs incurred for such treatment.<sup>16</sup>

Statutes are varied in existence and scope regarding consent for non-emergency medical care. Many states describe who can consent for

medical treatment for minors. Individuals standing en loco parentis are authorized to provide consent for necessary medical procedures.<sup>1,4,8,15</sup> In addition, consent for medical services can be provided by the court in most states.

The mature minor doctrine interfaces with both case studies. In Case 1, the initial phase of medical treatment is covered under the emergency medicine doctrine. However, as Winston becomes cognitively capable, he may be able to provide informed consent for medical treatment depending on the state in which the scenario takes place. Clearly, Winston's parents, once notified, become the avenue through which consent can be provided. In Case 2, interpretation of the mature minor doctrine may authorize Samantha to provide consent for her surgical repair.

Clearly, two issues confront the medical professional dealing with these cases. It is of primary importance to determine if a medical emergency exists. More care can be provided, in the absence of parental consent, to the individual whose medical condition is truly an emergency than to the individual for whom medical care may be necessary for return to athletic participation. A review of state statutes and appellate rulings would support the notion that, with or without parental consent, Winston would be treated. The precise nature of the treatment, once the emergency has been stabilized is not well defined.

While the former is concise—consent is not a major issue—the latter presents several topics. One of the dilemmas with the mature minor doctrine is the determination of the age at which an individual has sufficient mental capacity to understand suggested medical procedures and be able to assess the risks versus the proposed benefits of the procedures. The JJSP suggests that an individual be 16 years of age or older. For treat-

ment for mental disorders, the age of 14 is suggested, and, in many states, no lower limit is set for reproductive medical advice and treatment. Determining who constitutes a "mature minor" is as difficult in the courts as it is in society-at-large.<sup>1,10</sup>

Another topic which is raised also relates to age of mental competence. Many states require high school athletes to sign an assumption of risk prior to participation in sports. If athletes can understand and assume the risk of participation in sport,<sup>11</sup> can they also understand and assume the power to consent for medical procedures?

Finally, the mature minor doctrine often leaves a great deal of ambiguity regarding financial obligations for the medical care provided a minor. Implicit in many statutes is the assumption that payment for services will be rendered.<sup>1</sup> This is not always the case. In *Missouri Osteopathic Foundation v. Ott*,<sup>12</sup> a father was not held liable for charges incurred by his daughter for medical care for which he did not consent. The court stated that the Missouri statute clearly indicates that a parent must expressly agree to pay for services to be held financially liable.

## Conclusion

Case 1 is clearly covered by the emergency medicine doctrine which states that, when parental consent cannot be obtained, necessary medical treatment is authorized. A host of other legal issues can be raised which are beyond the scope of this discussion. What is the role of a minor student athletic trainer in the provision of medical care to a minor patient? Does the school have any responsibility to provide trained medical personnel at all practices? The court in *Montgomery v. City of Detroit*,<sup>13</sup> a case brought by the parents of a student who died of a heart attack on the athletic field, failed to hold the school or school personnel liable for not having trained medical personnel

covering athletic events. What is the purpose and scope of obtaining parental consent for medical care prior to an athletic season?

Case 2 is not a medical emergency. For the surgical correction of the shoulder subluxations, consent must be provided. The question in Case 2 is: "Who is authorized to provide this consent?" Unanswered questions are also present. "Who will pay for the procedure?" If Samantha's parents do not want to consent to the surgery, can she, under the mature minor doctrine, go against their wishes?

When providing emergency medical care to minors, lack of parental consent does not limit the provision of necessary medical care to prevent damage to the life or health of a minor. When an emergency is not present, consent must be obtained. When the patient is a minor, the parent is the optimal consent-giver. However, the mature minor may be authorized to provide consent. Athletic trainers and other allied health practitioners who often find themselves dealing with a minor population should be familiar with emergency medicine and mature minor statutes in the states in which they are employed.

## References

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